

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037317</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lexington of Elmhurst</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/1/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>420 W. Butterfield Road</u> <u>Elmhurst</u> <u>60126</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>DuPage</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(630) 832-2300</u> Fax # <u>(630) 832-7043</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
IDPA ID Number: <u>363682838001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>11/12/91</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst# 0037317 Report Period Beginning: 01/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 12/1/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>148</u>	Skilled (SNF)	<u>150</u>	<u>54,082</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>148</u>	TOTALS	<u>150</u>	<u>54,082</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,294</u>	<u>5,351</u>	<u>5,082</u>	<u>27,727</u>	8
9	SNF/PED					9
10	ICF	<u>8,756</u>	<u>11,633</u>	<u>227</u>	<u>20,616</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,050</u>	<u>16,984</u>	<u>5,309</u>	<u>48,343</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.39%

D. How many bed-hold days during this year were paid by Public Aid?

35 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/12/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New constructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 26 and days of care provided 4,635Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/1/01

Ending:

12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	275,070	24,728	9,841	309,639		309,639		309,639			1
2	Food Purchase		208,747		208,747		208,747	(10,862)	197,885			2
3	Housekeeping	216,151	28,796		244,947		244,947		244,947			3
4	Laundry	45,077	19,875		64,952		64,952	(4,331)	60,621			4
5	Heat and Other Utilities			186,863	186,863		186,863	2,115	188,978			5
6	Maintenance	62,012		102,073	164,085		164,085	1,376	165,461			6
7	Other (specify):*											7
8	TOTAL General Services	598,310	282,146	298,777	1,179,233		1,179,233	(11,702)	1,167,531			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	2,054,985	128,839	12,730	2,196,554		2,196,554		2,196,554			10
10a	Therapy			548,264	548,264		548,264		548,264			10a
11	Activities	141,705	19,307	5,523	166,535		166,535		166,535			11
12	Social Services	32,881		6,499	39,380		39,380		39,380			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,229,571	148,146	584,016	2,961,733		2,961,733		2,961,733			16
	C. General Administration											
17	Administrative	149,884		278,418	428,302		428,302	(278,418)	149,884			17
18	Directors Fees											18
19	Professional Services			60,807	60,807		60,807	1,912	62,719			19
20	Dues, Fees, Subscriptions & Promotions			35,064	35,064		35,064	2,177	37,241			20
21	Clerical & General Office Expenses	327,713	35,366	23,118	386,197		386,197	12,619	398,816			21
22	Employee Benefits & Payroll Taxes			359,777	359,777		359,777	40,826	400,603			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,343	2,343		2,343	1,106	3,449			24
25	Other Admin. Staff Transportation							6,398	6,398			25
26	Insurance-Prop.Liab.Malpractice			78,326	78,326		78,326	1,575	79,901			26
27	Other (specify):*											27
28	TOTAL General Administration	477,597	35,366	837,853	1,350,816		1,350,816	(211,805)	1,139,011			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,305,478	465,658	1,720,646	5,491,782		5,491,782	(223,507)	5,268,275			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Lexington of Elmhurst

#0037317

Report Period Beginning:

01/1/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			26,566	26,566		26,566	148,857	175,423			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25	25		25	244,221	244,246			32
33	Real Estate Taxes							63,431	63,431			33
34	Rent-Facility & Grounds			842,228	842,228		842,228	(842,228)				34
35	Rent-Equipment & Vehicles			2,892	2,892		2,892	435	3,327			35
36	Other (specify):*											36
37	TOTAL Ownership			871,711	871,711		871,711	(385,284)	486,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,692	7,678	115,370		115,370		115,370			39
40	Barber and Beauty Shops			29,517	29,517		29,517		29,517			40
41	Coffee and Gift Shops			783	783		783		783			41
42	Provider Participation Fee			81,123	81,123		81,123		81,123			42
43	Other (specify):* Nonallowable costs			(9,666)	(9,666)		(9,666)	9,666				43
44	TOTAL Special Cost Centers		107,692	109,435	217,127		217,127	9,666	226,793			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,305,478	573,350	2,701,792	6,580,620		6,580,620	(599,125)	5,981,495			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/1/01

Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(926)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,330)	4		8
9	Non-Straightline Depreciation	1,692	30		9
10	Interest and Other Investment Income	(28,133)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,270)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(380)	43		18
19	Entertainment	(134)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,214)	43		24
25	Fund Raising, Advertising and Promotional	(7,340)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	29,954	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(3,969)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,050)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(573,075)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (573,075)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (599,125)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/01 - 12/31/01

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(2,558)	19
Out of period legal fees	(497)	19
Miscellaneous income offset	(1,585)	21
Deferred maintenance amort.	671	6
Total	<u>(3,969)</u>	

See Accountants' Compilation Report

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 01/1/01

Ending: 12/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/1/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(926)	0	0	0	0	0	0	0	0	0	0	(926)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,330)	0	0	0	0	0	0	0	0	0	0	(4,330)	4
5	Heat and Other Utilities	0	0	2,115	0	0	0	0	0	0	0	0	2,115	5
6	Maintenance	0	0	705	0	0	0	0	0	0	0	0	705	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,256)	0	2,820	0	0	0	0	0	0	0	0	(2,436)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(278,418)	0	0	0	0	0	0	0	(278,418)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	68	4,899	0	0	0	0	0	0	0	0	4,967	19
20	Fees, Subscriptions & Promotions	0	0	2,177	0	0	0	0	0	0	0	0	2,177	20
21	Clerical & General Office Expenses	0	48	14,156	0	0	0	0	0	0	0	0	14,204	21
22	Employee Benefits & Payroll Taxes	0	0	30,889	0	0	0	0	0	0	0	0	30,889	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,106	0	0	0	0	0	0	0	0	1,106	24
25	Other Admin. Staff Transportation	0	0	6,398	0	0	0	0	0	0	0	0	6,398	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,575	0	0	0	0	0	0	0	1,575	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	116	59,625	(276,843)	0	0	0	0	0	0	0	(217,102)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,256)	116	62,445	(276,843)	0	0	0	0	0	0	0	(219,538)	29

Summary B

12/31/01

[illegible]

Facility Name & ID Number Lexington of Elmhurst# 0037317

Report Period Beginning:

01/1/01

Ending:

12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	16.66%			Sambell of Elmhurst		
John Samatas	16.67%			II Ltd. Ptsp.	Elmhurst	Real estate ptsp.
Cynthia Thiem	16.67%	See attached Schedule B		Royal Mgmt. Corp.	Lombard	Mgmt. Co.
Jeffrey J. Bell Revocable Trust	8.25%			Lexington Financial		
Lawrence W. Bell Declaration of Trust	8.25%			Services II, L.L.C.	Lombard	Finance Co.
David S. Bell Declaration of Trust	8.25%					
Dorothy D. Bell Declaration of Trust	8.25%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental expense	\$ 842,228	Sambell of Elmhurst II Limited Partnership	**	\$	\$ (842,228)	1
2	V	19 Professional fees		Sambell of Elmhurst II Limited Partnership	**	68	68	2
3	V	21 Bank charges		Sambell of Elmhurst II Limited Partnership	**	48	48	3
4	V	30 Depreciation		Sambell of Elmhurst II Limited Partnership	**	138,485	138,485	4
5	V	32 Interest expense		Sambell of Elmhurst II Limited Partnership	**	269,073	269,073	5
6	V	32 Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	2,429	2,429	6
7	V	33 Property taxes		Sambell of Elmhurst II Limited Partnership	**	62,228	62,228	7
8	V	43 State replacement tax		Sambell of Elmhurst II Limited Partnership	**	50	50	8
9	V							9
10	V			** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				10
11	V			of Sambell of Elmhurst II Limited Partnership				11
12	V							12
13	V							13
14	Total		\$ 842,228			\$ 472,381	\$ * (369,847)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/1/01

Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities - gas & electric	\$	Royal Management Corp.	**	\$ 1,871	\$ 1,871
16	V	5 Utilities - water & sewer		Royal Management Corp.	**	244	244
17	V	6 Repairs & maintenance		Royal Management Corp.	**	491	491
18	V	6 Scavenger & exterminating		Royal Management Corp.	**	205	205
19	V	6 Security service		Royal Management Corp.	**	9	9
20	V	19 Computer consultant & supplies		Royal Management Corp.	**	3,746	3,746
21	V	19 Professional fees		Royal Management Corp.	**	1,153	1,153
22	V	20 Advertising - help wanted		Royal Management Corp.	**	1,782	1,782
23	V	20 Dues & subscriptions		Royal Management Corp.	**	395	395
24	V	21 Bank charges		Royal Management Corp.	**	2,134	2,134
25	V	21 Communications		Royal Management Corp.	**	386	386
26	V	21 Office supplies & printing		Royal Management Corp.	**	4,604	4,604
27	V	21 Postage		Royal Management Corp.	**	1,944	1,944
28	V	21 Telephone		Royal Management Corp.	**	5,088	5,088
29	V	22 FICA		Royal Management Corp.	**	18,949	18,949
30	V	22 FUTA		Royal Management Corp.	**	391	391
31	V	22 SUTA		Royal Management Corp.	**	740	740
32	V	22 Insurance - W/C		Royal Management Corp.	**	239	239
33	V	22 Insurance - Hospitalization		Royal Management Corp.	**	7,913	7,913
34	V	22 401(k) and other emp. benefits		Royal Management Corp.	**	2,657	2,657
35	V	24 Travel & seminar		Royal Management Corp.	**	1,106	1,106
36	V	25 Auto expense		Royal Management Corp.	**	6,398	6,398
37	V						
38	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 62,445	\$ * 62,445

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/1/01

Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	26 Insurance - general	\$	Royal Management Corp.	**	\$ 1,575	\$ 1,575
16	V	30 Depreciation - vehicles		Royal Management Corp.	**	2,664	2,664
17	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	1,640	1,640
18	V	30 Depreciation - equipment		Royal Management Corp.	**	4,376	4,376
19	V	32 Interest		Royal Management Corp.	**	852	852
20	V	33 Property taxes		Royal Management Corp.	**	1,203	1,203
21	V	35 Equipment rental		Royal Management Corp.	**	435	435
22	V	17 Management	278,418	Royal Management Corp.	**		(278,418)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.					
39	Total		\$ 278,418			\$ 12,745	\$ * (265,673)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/01 - 12/31/01

Schedule B

VII. Related Parties
Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.
Lexington Health Care Center of Bloomingdale, Inc.
Lexington Health Care Center of Chicago Ridge, Inc.
Lexington Health Care Center of LaGrange, Inc.
Lexington Health Care Center of Lake Zurich, Inc.
Lexington Health Care Center of Schaumburg, Inc.
Lexington Health Care Center of Streamwood, Inc.
Lexington Health Care Center of Wheeling, Inc.
Lexington Health Care Center of Orland Park, Inc.

Lombard
Bloomingdale
Chicago Ridge
LaGrange
Lake Zurich
Schaumburg
Streamwood
Wheeling
Orland Park

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	16.66%	See Schedule C	3	6%	Salary	\$ 26,672	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	16.67%	See Schedule C	1	2%	Salary	11,728	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	16.67%	See Schedule C	1	2%	Salary	14,718	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	2%	Salary	6,009	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	2	4%	Salary	8,110	L 17, C 1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 67,237		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/01 - 12/31/01

Schedule C

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	13,615	30,961	17,085	6,975	9,414	78,050
Lexington Health Care Center of Chicago Ridge, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of LaGrange, Inc.	8,628	19,621	10,827	4,420	5,966	49,462
Lexington Health Care Center of Lake Zurich, Inc.	16,123	36,664	20,230	8,260	11,148	92,425
Lexington Health Care Center of Lombard, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Orland Park, Inc.	20,900	47,523	26,222	10,707	14,447	119,799
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Wheeling, Inc.	17,495	39,783	21,953	8,961	12,097	100,289
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
<hr/>						
Total	151,297	344,045	189,845	77,508	104,607	867,302

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst# 0037317

Report Period Beginning:

01/1/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.Street Address 665 W. North Avenue, Suite 500City / State / Zip Code Lombard, IL 60148Phone Number (630) 458-4700Fax Number (630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - gas & electric	Bed Days	751,703	11	\$ 26,007	\$ 54,082	\$ 1,871	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397	54,082	244	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818	54,082	491	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851	54,082	205	4
5	6	Security Service	Bed Days	751,703	11	125	54,082	9	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068	54,082	3,746	6
7	19	Professional fees	Bed Days	751,703	11	16,027	54,082	1,153	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766	54,082	1,782	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496	54,082	395	9
10	21	Bank charges	Bed Days	751,703	11	29,664	54,082	2,134	10
11	21	Communications	Bed Days	751,703	11	5,359	54,082	386	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988	54,082	4,604	12
13	21	Postage	Bed Days	751,703	11	27,021	54,082	1,944	13
14	21	Telephone	Bed Days	751,703	11	70,716	54,082	5,088	14
15	22	FICA	Bed Days	751,703	11	263,374	54,082	18,949	15
16	22	FUTA	Bed Days	751,703	11	5,433	54,082	391	16
17	22	SUTA	Bed Days	751,703	11	10,292	54,082	740	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319	54,082	239	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982	54,082	7,913	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931	54,082	2,657	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373	54,082	1,106	21
22	25	Auto expense	Bed Days	751,703	11	88,927	54,082	6,398	22
23									23
24									24
25	TOTALS				\$ 867,934	\$		\$ 62,445	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.
 Street Address 665 W. North Avenue, Suite 500
 City / State / Zip Code Lombard, IL 60148
 Phone Number (630) 458-4700
 Fax Number (630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26 Insurance - general	Bed Days	751,703	11	\$ 21,896	\$	54,082	\$ 1,575	1
2	30 Depreciation - vehicles	Bed Days	751,703	11	37,022		54,082	2,664	2
3	30 Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		54,082	1,640	3
4	30 Depreciation - equipment	Bed Days	751,703	11	60,826		54,082	4,376	4
5	32 Interest	Bed Days	751,703	11	11,844		54,082	852	5
6	33 Property taxes	Bed Days	751,703	11	16,719		54,082	1,203	6
7	35 Equipment rental	Bed Days	751,703	11	6,049		54,082	435	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 177,145	\$		\$ 12,745	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	Lexington Financial Services, L.L.C. II	x		Mortgage	Varies	12/29/98	\$ 4,256,000	\$ 3,931,252	01/2008	0.0675	\$ 269,098	2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 4,256,000	\$ 3,931,252			\$ 269,098	9							
	B. Non-Facility Related*																		
10								Amortization of loan costs			2,429	10							
11								Interest income offset			(28,133)	11							
12								Allocated from management company			852	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (24,852)	14							
15	TOTALS (line 9+line14)						\$ 4,256,000	\$ 3,931,252			\$ 244,246	15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lexington of Elmhurst**# **0037317** Report Period Beginning: **01/1/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.			\$	66,000	1
		Allocated from Management Company		1,203	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	\$	62,228		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,569)		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	66,000		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	63,431		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	60,059	8		
	1997	62,018	9		
	1998	62,599	10		
	1999	63,573	11		
	2000	62,228	12		
2000 taxes:	62,228				
Estimated increase (6%):	1.06				
Estimated 2001 taxes:	65,961				
Use:	66,000				
				FOR OHF USE ONLY	
				13 FROM R. E. TAX STATEMENT FOR 2000 \$	13
				14 PLUS APPEAL COST FROM LINE 5 \$	14
				15 LESS REFUND FROM LINE 6 \$	15
				16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Elmhurst COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-14-317-008</u>	<u>Land and building</u>	\$ <u>62,227.58</u>	\$ <u>62,227.58</u>
2. <u>Royal Management Corp. (Omni Partners)</u>		\$ _____	\$ _____
3. <u>06-19-201-018</u>	<u>Land and building</u>	\$ <u>68,214.22</u>	\$ <u>1,203.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>130,441.80</u></u>	\$ <u><u>63,430.58</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

52,608

B. General Construction Type:

Exterior

Concrete Block

Frame

Steel

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lexington Square Life Care of Elmhurst, Inc.; Continuing Care Retirement Community; 342 units; 485,300 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	55,000	1991	\$ 1,277,670	1
2					2
3	TOTALS	55,000		\$ 1,277,670	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning:

01/1/01

Ending:

12/31/01

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1991	1991	\$ 4,110,586	\$	35	\$ 117,445	\$ 117,445	\$ 1,188,917	4
5	10		1995	1995	73,302	2,095	35	2,095		13,941	5
6	2		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement		1992		693	20	35	20		184	9
10	Land Improvement		1995		7,500	500	15	500		3,167	10
11	Fan Coil Units		1996		4,903	140	35	140		771	11
12	Patio		1996		2,322	155	15	155		851	12
13	Basement rehab		1997		17,151	1,715	10	1,715		7,575	13
14	Baseboards		1997		3,129	313	10	313		1,330	14
15	Wiring		1998		3,090	309	10	309		1,082	15
16	Lobby Tile		1999		19,354	1,935	10	1,935		5,645	16
17	Patio		1999		4,196	280	15	280		559	17
18	Automatic Door		2000		1,300	130	10	130		195	18
19	Wallpaper		2000		6,853	685	10	685		1,028	19
20	Patio		2000		1,242	83	15	83		124	20
21	Storage closet for HVAC		2000		3,745	250	15	250		374	21
22	Fire pump system		2001		4,141	207	10	207		207	22
23	Door releases		2001		4,420	221	10	221		221	23
24	Infrared curtains for elevators		2001		3,000	150	10	150		150	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Allocated from management company	1995	\$ 7,225	\$		\$ 224	\$ 224	\$ 1,342		37
38	Allocated from management company	1996	5,880			182	182	924		38
39	Allocated from management company	1989	203			6	6	89		39
40	Allocated from management company - HVAC	1998	152			5	5	17		40
41	Allocated from management company - Offices	1999	384			12	12	27		41
42	Allocated from management company - Offices	2000	182			6	6	9		42
43	Allocated from management company	1987	37,179			1,152	1,152	16,283		43
44	Allocated from management company	1993	20			1	1	4		44
45	Allocated from management company	1995	838			26	26	139		45
46	Allocated from management company	1996	168			5	5	23		46
47	Allocated from management company - Sidewalk	1998	350			11	11	30		47
48	Allocated from management company - Roof	1998	13			0	0	4		48
49	Allocated from management company - Awnings	1999	99			3	3	6		49
50	Allocated from management company - Parking lot	1999	216			7	7	50		50
51	Allocated from management company - Facade	2001	31			1	1	1		51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 4,323,867	\$ 9,188		\$ 128,273	\$ 119,085	\$ 1,245,269		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 373,615	\$ 15,696	\$ 38,428	\$ 22,732	5-10 years	\$ 331,750	71
72	Current Year Purchases	18,416	1,682	1,682		5 years	1,682	72
73	Fully Depreciated Assets	8,227					8,227	73
74	Allocated from Management Company	47,273		4,376	4,376		34,347	74
75	TOTALS	\$ 447,531	\$ 17,378	\$ 44,486	\$ 27,108		\$ 376,006	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79	Allocated from Management Company			21,400		2,664	2,664		13,941	79
80	TOTALS			\$ 21,400	\$	\$ 2,664	\$ 2,664		\$ 13,941	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,070,468	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,566	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 175,423	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 148,857	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,635,216	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Rehabilitation	\$ 47,822	92
93			93
94			94
95		\$ 47,822	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 3,327 Description: Postage Meter - \$426; Copier - \$2,466; Allocated from Management Company - \$435

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$

13. /2003 \$

14. /2004 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	L10A, C3	hrs	\$	
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		401	23,725		401	23,725	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		6,510	316,969		6,510	316,969	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				97,733		97,733	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify): See attached Schedule D					7,678	9,959		17,637	13
14	TOTAL			\$	10,709	\$ 555,942	\$ 107,692	10,709	\$ 663,634	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/01 - 12/31/01

Schedule D

XIV. Special Services (Direct Cost)
Line 13, Other

<u>Service</u>	<u>Cost</u>	<u>Line Reference</u>
Oxygen	9,959	L 39, C2
Laboratory	1,902	L 39, C3
Radiology	1,054	L 39, C3
Ambulance	13	L 39, C3
Dentist	300	L 39, C3
Clinitron beds	4,409	L 39, C3
Total	<u>17,637</u>	

See Accountants' Compilation Report

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 286,398	\$ 289,896	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,000)	1,600,110	1,600,110	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,415	36,415	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	52,253	52,253	8
9	Other(specify): Escrow	14,000	45,600	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,989,176	\$ 2,024,274	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,645	4,645	12
13	Land		1,277,670	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	160,341	213,281	15
16	Equipment, at Historical Cost	129,264	468,931	16
17	Accumulated Depreciation (book methods)	(110,615)	(1,635,216)	17
18	Deferred Charges		191	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Construction in progr	47,822	47,822	22
23	Other(specify): Unamortized loan costs		41,301	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 231,457	\$ 4,529,211	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,220,633	\$ 6,553,485	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 221,264	\$ 221,264	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,532	88,532	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,554	2,554	31
32	Accrued Real Estate Taxes(Sch.IX-B)		66,000	32
33	Accrued Interest Payable		22,113	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	136,057	57,493	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 448,407	\$ 457,956	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,931,252	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,931,252	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 448,407	\$ 4,389,208	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,772,226	\$ 2,164,277	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,220,633	\$ 6,553,485	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/01 - 12/31/01

Schedule E

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	78,564	-
Accrued management fees	19,746	19,746
Accrued 401 (k) contribution	7,680	7,680
401 (k) withholding	4,552	4,552
Other accrued expenses	25,515	25,515
	<hr/>	<hr/>
Total line 36	<u>136,057</u>	<u>57,493</u>

XVII. Income Statement
E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Investment in Lexington Financial Services, L.L.C. II	1,191
Miscellaneous income	1,585
	<hr/>
Total line 28	<u>2,776</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,483,774	1
2	Restatements (describe):		2
3	Prior year post closing entries	(126,300)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,357,474	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,620,752	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,206,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 414,752	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,772,226	24 *

Operating entity only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/1/01

Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,401,063	1
2	Discounts and Allowances for all Levels	(396,603)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,004,460	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	944,364	6
7	Oxygen	7	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 944,371	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	114	12
13	Barber and Beauty Care	36,888	13
14	Non-Patient Meals	926	14
15	Telephone, Television and Radio	58	15
16	Rental of Facility Space		16
17	Sale of Drugs	108,986	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,724	19
20	Radiology and X-Ray	1,243	20
21	Other Medical Services	60,362	21
22	Laundry	4,331	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 221,632	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	28,133	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,133	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	2,776	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,776	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,201,372	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	1,179,233	31
32	Health Care	2,961,733	32
33	General Administration	1,350,816	33
B. Capital Expense			
34	Ownership	871,711	34
C. Ancillary Expense			
35	Special Cost Centers	136,004	35
36	Provider Participation Fee	81,123	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,580,620	40
41	Income before Income Taxes (line 30 minus line 40)**	1,620,752	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,620,752	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files a cash basis tax return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of Elmhurst# 0037317Report Period Beginning: 01/1/01Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,855	1,855	\$ 66,100	\$ 35.63	1
2	Assistant Director of Nursing	1,983	1,999	50,292	25.16	2
3	Registered Nurses	33,381	35,631	785,527	22.05	3
4	Licensed Practical Nurses	12,187	12,909	247,912	19.20	4
5	Nurse Aides & Orderlies	71,730	74,710	780,349	10.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,899	10,479	124,805	11.91	8
9	Activity Director	434	434	5,588	12.88	9
10	Activity Assistants	15,763	16,508	136,117	8.25	10
11	Social Service Workers	2,644	2,759	32,881	11.92	11
12	Dietician	75	80	2,228	27.85	12
13	Food Service Supervisor	1,915	2,060	32,097	15.58	13
14	Head Cook	2,160	2,214	21,515	9.72	14
15	Cook Helpers/Assistants	17,221	18,005	145,693	8.09	15
16	Dishwashers	10,943	11,535	73,537	6.38	16
17	Maintenance Workers	2,396	2,568	62,012	24.15	17
18	Housekeepers	31,697	33,075	216,151	6.54	18
19	Laundry	6,932	7,358	45,077	6.13	19
20	Administrator	2,085	2,124	82,647	38.91	20
21	Assistant Administrator					21
22	Other Administrative	494	497	67,237	135.29	22
23	Office Manager					23
24	Clerical	20,376	21,637	327,713	15.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	246,170	258,437	\$ 3,305,478 *	\$ 12.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,841	L 1, C 3	35
36	Medical Director	Monthly	11,000	L 9, C 3	36
37	Medical Records Consultant	33	1,650	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,523	L 11, C 3	44
45	Social Service Consultant	Monthly	6,499	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	33	\$ 35,713		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	172	\$ 3,446	L 10, C 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	172	\$ 3,446		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

0037317

Report Period Beginning: 01/1/01

Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%		Description	Amount	Description	Amount	
Mark Murphy	Administrator	0%	\$ 63,231	Workers' Compensation Insurance	\$ 34,744	IDPH License Fee	\$ 200	
Frank Santore	Administrator	0%	19,416	Unemployment Compensation Insurance	24,793	Advertising: Employee Recruitment	33,285	
John Samatas	Admin/Plant Ops	16.67	11,728	FICA Taxes	253,278	Health Care Worker Background Check		
James Samatas	Administrative	16.66	26,672	Employee Health Insurance	56,834	(Indicate # of checks performed <u>25</u>)	326	
Cynthia Thiem	Administrative	16.67	14,718	Employee Meals	9,936	Miscellaneous dues & subscriptions	508	
George Samatas	Administrative	0%	6,009	Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous licenses and permits	745	
Jason Samatas	Administrative	0%	8,110	401(k) Contribution	9,373			
TOTAL (agree to Schedule V, line 17, col. 1)				Other Employee Benefits	11,645			
(List each licensed administrator separately.)			\$ 149,884					
B. Administrative - Other						Allocated from Management Company	2,177	
Description		Amount				Less: Public Relations Expense	()	
Management fees (eliminated in column 7)		\$ 278,418				Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 278,418	TOTAL (agree to Schedule V, line 22, col.8)	\$ 400,603	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 37,241	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount					Out-of-State Travel	\$
Aetna Life Insurance & Annuity	401(k) administration	\$ 210						
Altschuler, Melvoin & Glasser LLP	Accounting	13,359					In-State Travel	
American Express Tax & Bus Srv	Accounting	6,634						
Systematic Management	Consulting	4,091						
Freidman, Anselmo & Lindberg	Collections	2,558						
A-One Recruiting	Recruiting	9,450					Seminar Expense	2,343
Personnel Planners	U/C Consulting	1,519					Allocated from Management Company	1,106
James Samatas	Legal	50						
Chicago Hearing Society	Consulting	335					Entertainment Expense	()
Environetx	Space Consulting	242					(agree to Sch. V, line 24, col. 8)	
Royal Management Corp.	Web site development	369					TOTAL	\$ 3,449
See attached Schedule F		21,990						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 60,807					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lexington Health Care Center of Elmhurst, Inc.
 Provider # 0037317
 1/1/00 - 12/31/00

Schedule F

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Marc Murphy	Recruitment	15,000
Robert Stachura	Accounting	27
Sachnoff & Weaver	Legal	3,051
Advanced Information Management	Software maintenance	2,735
Information Controls, Inc.	Computer Consulting	1,177
Total, Other Professional Services		<u>21,990</u>
Total, Agrees to Schedule V, Line 19, Column 3		60,807
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/		
American Express Tax & Business Services	Accounting	747
James Samatas	Filing and recording fees	3
Sachnoff & Weaver	Legal	37
BDO Seidman, LLP	Accounting	11
Robert Stachura	Accounting	2
Pension Administrators / Aetna Life Ins & Annuity	401 (k) Administration	158
Various	Consulting	195
Various	Computer Services	3,746
Allocated from building partnership		
James Samatas	Filing and recording fees	68
Nonallowable legal fees		
Freidman, Anselmo, & Lindberg	Legal-collection fees	(2,558)
Sachnoff & Weaver	Out of period legal fees	(497)
Total, Agrees to Schedule V, Line 19, Column 8		<u>62,719</u>

See accountants' compilation report.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Deferred maintenance	7/98	\$ 1,720	3 yrs	\$ 287	\$ 573	\$ 573	\$ 287	\$	\$	\$	\$	\$
2	Painting & decorating	12/99	1,151	3 yrs		192	384	384	191				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,871		\$ 287	\$ 765	\$ 957	\$ 671	\$ 191	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst

STATE OF ILLINOIS

0037317

Report Period Beginning:

01/1/01

Ending:

Page 23

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,849 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 81,123
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 9,936 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 926
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? Adequate records are maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	275,070	24,728	9,841	309,639	0	309,639	0	309,639
2. Food Pr	0	208,747	0	208,747	0	208,747	-10,862	197,885
3. Housek	216,151	28,796	0	244,947	0	244,947	0	244,947
4. Laundry	45,077	19,875	0	64,952	0	64,952	-4,331	60,621
5. Heat an	0	0	186,863	186,863	0	186,863	2,115	188,978
6. Mainten	62,012	0	102,073	164,085	0	164,085	1,376	165,461
7. Other (s	0	0	0	0	0	0	0	0
8. Total Gr	598,310	282,146	298,777	1,179,233	0	1,179,233	-11,702	1,167,531
9. Medical	0	0	11,000	11,000	0	11,000	0	11,000
10. Nursin	2,054,985	128,839	12,730	2,196,554	0	2,196,554	0	2,196,554
10a. Ther:	0	0	548,264	548,264	0	548,264	0	548,264
11. Activiti	141,705	19,307	5,523	166,535	0	166,535	0	166,535
12. Social	32,881	0	6,499	39,380	0	39,380	0	39,380
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	2,229,571	148,146	584,016	2,961,733	0	2,961,733	0	2,961,733
17. Admin	149,884	0	278,418	428,302	0	428,302	-278,418	149,884
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	60,807	60,807	0	60,807	1,912	62,719
20. Fees,	0	0	35,064	35,064	0	35,064	2,177	37,241
21. Clerics	327,713	35,366	23,118	386,197	0	386,197	12,619	398,816
22. Emplo	0	0	359,777	359,777	0	359,777	40,826	400,603
23. Inservi	0	0	0	0	0	0	0	0
24. Travel	0	0	2,343	2,343	0	2,343	1,106	3,449
25. Other .	0	0	0	0	0	0	6,398	6,398
26. Insura	0	0	78,326	78,326	0	78,326	1,575	79,901
27. Other	0	0	0	0	0	0	0	0
28. Total C	477,597	35,366	837,853	1,350,816	0	1,350,816	-211,805	1,139,011
29. Total C	3,305,478	465,658	1,720,646	5,491,782	0	5,491,782	-223,507	5,268,275
30. Deprec	0	0	26,566	26,566	0	26,566	148,857	175,423
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	25	25	0	25	244,221	244,246
33. Real E	0	0	0	0	0	0	63,431	63,431
34. Rent -	0	0	842,228	842,228	0	842,228	-842,228	0
35. Rent -	0	0	2,892	2,892	0	2,892	435	3,327
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	871,711	871,711	0	871,711	-385,284	486,427
38. Medic:	0	0	0	0	0	0	0	0
39. Ancilla	0	107,692	7,678	115,370	0	115,370	0	115,370
40. Barber	0	0	29,517	29,517	0	29,517	0	29,517
41. Coffee	0	0	783	783	0	783	0	783
42. Provid	0	0	81,123	81,123	0	81,123	0	81,123
43. Other	0	0	-9,666	-9,666	0	-9,666	9,666	0
44. Total S	0	107,692	109,435	217,127	0	217,127	9,666	226,793
45. Grand	3,305,478	573,350	2,701,792	6,580,620	0	6,580,620	-599,125	5,981,495

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	286,398	289,896
2. Cash - F	0	0
3. Account	1,600,110	1,600,110
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	36,415	36,415
7. Other Pr	0	0
8. Account	52,253	52,253
9. Other (s	14,000	45,600
10. Total c	1,989,176	2,024,274
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	4,645	4,645
13. Land	0	1,277,670
14. Buildin	0	4,110,586
15. Lease	160,341	213,281
16. Equipm	129,264	468,931
17. Accum	-110,615	#####
18. Deferre	0	191
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	47,822	47,822
23. other (s	0	41,301
24. Total L	231,457	4,529,211
25. Total A	2,220,633	6,553,485
CURRENT LIABILITIES		
26. Accour	221,264	221,264
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	88,532	88,532
31. Accrue	2,554	2,554
32. Accrue	0	66,000
33. Accrue	0	22,113
34. Deferre	0	0
35. Federa	0	0
36. Other C	136,057	57,493
37. Other C	0	0
38. Total C	448,407	457,956
LONG TERM LIABILITES		
39.Long-T	0	0
40.Mortgaç	0	3,931,252
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lc	0	3,931,252
46.Total Li:	448,407	4,389,208
47.Total Et	1,772,226	2,164,277
48.Total Li:	2,220,633	6,553,485

Balance per
Medicaid
Trial Balance

1. Gross F 7,401,063
2. Discour -396,603

Subtota 7,004,460
4. Day Ca 0
5. Other C 0
6. Therap 944,364
7. Oxygen 7

Subtota 944,371
9. Paymer 0
10. Other 0
11. Nurse 0
12. Gift an 114
13. Barbe 36,888
14. Non-P 926
15. Teleph 58
16. Rental 0
17. Sale o 108,986
18. Sale o 0
19. Labor 8,724
20. Radiol 1,243
21. Other 60,362
22. Laund 4,331

Subtot 221,632
24. Contrl 0
25. Intere 28,133

Subtot 28,133
27. Other 2,776
28. Other 0
Subtot 2,776

30. Total F 8,201,372
31. Gener 1,179,233
32. Health 2,961,733
33. Gener 1,350,816
34. Owner 871,711
35. Specie 136,004
35. Provid 81,123
37. Other 0
40. Total F 6,580,620
41. Incom 1,620,752
42. Incom 0
43. Net In 1,620,752

Page

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under **, you must write in any comments

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RECONCILIATION REPORT

Lexington of Elmhurst

03:15 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-599,125	equal to	-599,125	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	244,246	equal to	244,246	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	63,431	equal to	63,431	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	175,423	equal to	175,423	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,327	equal to	3,327	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	548,264	equal to	548,264	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	107,692	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,179,233	equal to	1,179,233	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,961,733	equal to	2,961,733	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,350,816	equal to	1,350,816	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	871,711	equal to	871,711	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	136,004	equal to	136,004	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4
Income Stat. Prov. Partic.	81,123	equal to	81,123	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,930,180	equal to	2,054,985	-124,805	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	141,705	equal to	141,705	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	32,881	equal to	32,881	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	275,070	equal to	275,070	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	62,012	equal to	62,012	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	216,151	equal to	216,151	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	45,077	equal to	45,077	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	149,884	equal to	149,884	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	327,713	equal to	327,713	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,305,478	equal to	3,305,478	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,841	< or = to	9,841	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	11,000	< or = to	11,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	6,296	< or = to	12,730	-6,434	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	5,523	< or = to	5,523	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	6,499	< or = to	6,499	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	149,884	equal to	149,884	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	278,418	equal to	278,418	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	60,807	equal to	60,807	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	400,603	equal to	400,603	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	37,241	equal to	37,241	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,449	equal to	3,449	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	81,123	equal to	81,123	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	9,936	< or = to	40,826	-30,890	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	9,936	equal to	9,936	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	4,635	equal to	5,082	-447	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-573,075	equal to	-573,075	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(B.	14	8
Total loan balance	3,931,252	equal to	3,931,252	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	66,000	equal to	66,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	1,277,670	equal to	1,277,670	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,323,867	equal to	4,323,867	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	468,931	equal to	468,931	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,635,216	equal to	1,635,216	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,772,226	equal to	1,772,226	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	1,620,752	equal to	1,620,752	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	191	equal to	191	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,220,633	equal to	2,220,633	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1